NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

REQUEST TO INSPECT OR OBTAIN A COPY OF THE CLINICAL RECORD

PATIENT'S LAST NAME ,	FIRST	M.I.
CASE NO.		
FACILITY	UNIT	

INSTRUCTIONS:	This form must be completed and returned to your counselor in order to inspect or obtain a copy of your medical record. Information will be made available to you within 30 days from date of this request.

DISCLOSURE WITH PATIENT'S CONSENT

EXTENT OR NATURE OF INFORMATION TO BE INSPECTED/OBTAINED
PURPOSE OR NEED FOR INFORMATION
ADDRESS TO SEND REQUESTED INFORMATION
NAME OR TITLE OF PERSON OR ORGANIZATION DISCLOSING INFORMATION FROM:

I, the undersigned, have requested in writing that the above information, from my medical record, be made available to me. I understand that in order for me to obtain this information, I must submit this written request and that the information will be made available to me within 30 days of this request.

I understand that any disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to another party is forbidden without additional written authorization on my part.

NOTE: YOU WILL BE CHARGED A FEE FOR THE COPYING OF MATERIAL. THIS FEE IS $0.05 a page

_____ _____

(Signature of Patient) (Signature of Parent/Guardian, when required)

_____ _____

(Print Name of Patient) (Print Name of Parent/Guardian)

_____ _____

(Date) (Date)

Facility Action:

☐ Request approved.

☐ Request Denied. Reason for denial _____

_____

Director/Assistant Director DATE